Army-Baylor University Graduate Program in Health Care and Business Administration

Methods to increase access to care for the uninsured and the indigent in the Greater San Antonio Hospital Systems: A Policy Analysis.

A Graduate Management Project
In partial fulfillment of the requirements for a graduate degree in Management in Health care Administration

by
Janiese A. Cleckley, FACHE
LT, USN, MSC

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Health care coverage in the United States has decreased drastically over the past 10 years. This phenomenon is of tremendous concern as the number of uninsured persons in the United States has increased considerably from 33 million to over 46 million within a decade. Of all the states, Texas has the highest rates of uninsured and under-insured in the country. According to the Census Bureau, an estimated 24.6 percent of the total population or 5.4 million Texans were uninsured in 2004. For the 44-46 age cohorts, classified as non-elderly, the statewide uninsured rate was 27.3 percent. Specific to San Antonio, one in every four persons is uninsured. As a result, this lack of access to health care coverage has resulted in poor health outcomes, higher mortality rates, shorter life spans, low income, educational inadequacies, and low socio-economic standing in the community. The purpose of this policy analysis is to identify the best policy alternative(s) that will increase access to care for the uninsured in San Antonio, Texas and at the same time improve the soci-economic standing of the community as a whole.

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Disclaimer

The views expressed in this Policy analysis are those of the author and do not reflect the official policy or position of the Greater San Antonio Hospital Council, the Department of the Army, Department of the Navy or the United States Government.

Abstract

Health care coverage in the United States has decreased drastically over the past 10 years. This phenomenon is of tremendous concern as the number of uninsured persons in the United States has increased considerably from 33 million to over 46 million within a decade. Of all the states, Texas has the highest rates of uninsured and underinsured in the country. According to the Census Bureau, an estimated 24.6 percent of the total population, or 5.4 million Texans were uninsured in 2004. For the 44-64 age cohorts, classified as non-elderly, the statewide uninsured rate was 27.3 percent. Specific to San Antonio, one in every four persons is uninsured. This means that of the 1.5 million people in San Antonio, 372,000 residents are without health coverage. As a result, this lack of access to health care coverage has resulted in poor health outcomes, an unhealthy community, higher mortality rates, shorter life spans, low income, educational inadequacies, and low socio-economic standing in the community. The purpose of this policy analysis is to identify the best policy alternative(s) that will increase access to care for the uninsured in San Antonio Texas and at the same time improve the socio-economic standing of the community as a whole.

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Introduction

Health care insurance coverage in the United States has drastically changed over the past 10 years (Hill, 2004). This has greatly impacted the population's access to primary care providers for routine and preventative care. As an alternative, many uninsured turn to the emergency room as their primary source of medical care, which has resulted in, an increase in uncompensated care costs for the local San Antonio health care systems. Additionally, this lack of a health care home for the uninsured has had a negative effect on the socio-economic standing of the community. The purpose of this policy analysis is to identify the best policy alternative(s) that will increase access to care for the uninsured in San Antonio Texas and at the same time improve the socio-economic standing of the community as a whole.

The lack of health care coverage for the uninsured plays a major part in the overall poor health status of our citizens in the United States today. This phenomenon is of tremendous concern as the number of uninsured persons in the United States has increased considerably from 33 million to over 47 million within a decade. The contributing factors to this crisis in health care coverage are due in part to declines in employer-sponsored coverage and decreases in State and Federal funding. The lack of healthcare coverage affects not just the uninsured and underinsured but the entire nation. There is an economic impact, which presents financial burdens, environmental inadequacies, educational delinquencies and poor health outcomes such as increase in diseases, overcrowding of emergency rooms, higher mortality rates and shorter life-spans (Hill, 2004).

Lack of healthcare insurance and proper access to primary care homes, results in the inability to acquire proper care, thus negatively impacting on the quality of life. The ability to receive needed care, to implement and promote preventative healthcare, means a healthier

population with the potential for a more efficient work force. This will result in positive economic growth, better educational and financial outcomes. The inability to receive health care due to the lack of adequate or non-availability of health coverage, results in poor health which means increases in absenteeism both at work and from schools. This results in low productivity, low education levels, which in turn affects the socio-economic status of the population.

Evidence will justify the need for this policy analysis to include the urgency to increase coverage for employees of small business as well as the necessity to increase funding of the state Medicare Needy Spend Down programs and the Children's Health Insurance Program (CHIP). In addition, a list of policy alternatives will be provided as well as an evaluative criteria and a matrix to assist with the selection of the best alternatives to resolve the problem of access to primary care providers for the working poor. The policy analysis will conclude with an analysis of tradeoffs as well as recommendations for positive outcomes.

Evidence

Texas has the largest uninsured population in the entire country; therefore any change to its current funding mechanism in providing healthcare to this population will be detrimental to the health of its people and should ensure that access to healthcare is a priority. According to the U.S. Census Bureau, Texas is last in health insurance coverage and remains at the top of the list for the highest number of working uninsured and underinsured across the nation (U.S. Census, 2005). In a study done by the Texas Department of Health and Human Services (DHHS), the majority of Texans who are uninsured are the working poor and specifically these are of Hispanic origin between the ages of 25-62 (DHHS, 2003). According to the Texas Department of Insurance, 21.4 percent of Texans are uninsured, compared to the national average of 14 percent. Of the 3 million people in the state who are uninsured 68.7 percent are employed. However, due

to the high cost of offering health insurance, small business' employees continue to go without insurance (Texas Department of Insurance, 2005).

An expansive literature review and explanation of the factors that have attributed to the increase in the uninsured and underinsured will be discussed in detail. Figure 1 will serve as a reference point for some of the major issues that are associated with providing care to the uninsured. For purposes of this paper only a select few of the facets of the uninsured will be addressed. These include the effects of and the need for government subsidized programs as well as the financial and the economical implications which result from providing care to the uninsured. The discussion will begin with a broad view of Texas and the uninsured and underinsured and narrow its focus to the effects of the uninsured on Bexar County, San Antonio.

Poverty and the uninsured in Texas

Over the years, the state of Texas has realized a vast increase not only in population but also in the number of uninsured and underinsured. Two reports, *Income, Poverty and Health Insurance Coverage in the United States, 2005*, and the Texas Comptroller's report of 2006, noted that one in every four Texan is without health care insurance coverage. Further studies by the U.S. Census Bureau noted that Texas has 60 percent higher than average prevalence of uninsured individuals than in the rest of the country. Between 2001 and 2003, the Census Bureau reported 36 percent uninsured in Laredo, 17.9 in Austin, 27.5 percent in Houston, 25.3 percent in Dallas, 23.6 percent in Fort Worth-Arlington and 24.3 percent in San Antonio. Specific to children, 25.1 percent of all Texas children were uninsured compared to the national average of 15.5 percent (U.S Census Report, 2004). The lack of health insurance leads to other deficiencies such as poor health, lower educational levels, and low income.

In a study done by Acs, McKenzie & Phillips (2000), evidence indicated that there is a direct correlation between poor health outcomes and the lack of insurance. The study indicated that health problems are more prevalent among the working poor or the low-income working family due to the lack of health insurance coverage by employers. Additionally, Acs et al., noted that 16% of fulltime workers in low income families reported a fair to poor overall health compared to middle income families with an overall health outcome of 7%.

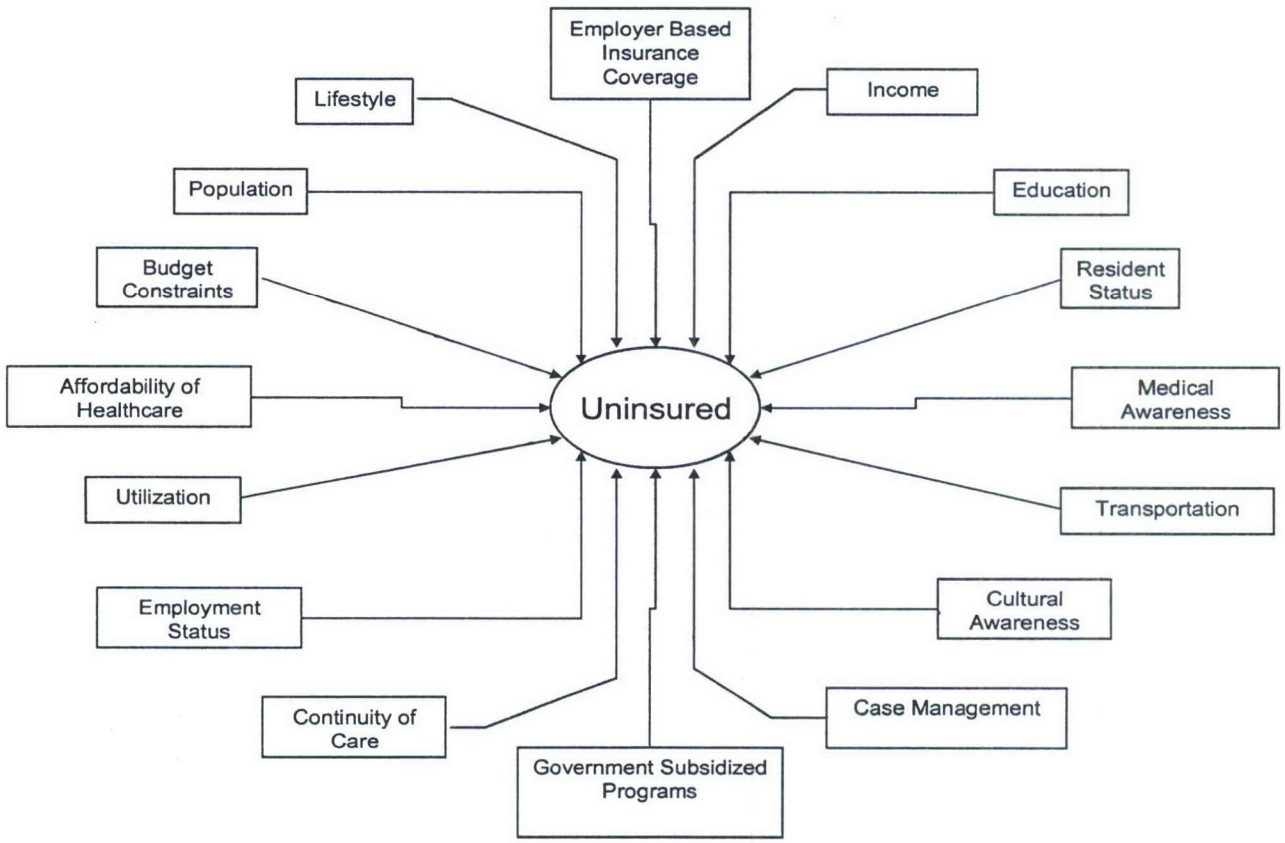

Figure 1. Facets for consideration when providing care to the uninsured.

The uninsured and underinsured

It is important to clarify the common myth about who the uninsured really are. Most people may think that the uninsured and underinsured in Texas are mostly immigrants especially

the illegal or undocumented immigrant component of the population, however, studies released by the Code Red Texas 2006 report showed that the uninsured and underinsured were predominately white collared moderate to low income employees. By definition the uninsured are those members of the population who are lacking health insurance coverage. The term underinsured is generally used to describe individuals who are exposed to significant financial losses or are unable to obtain the needed health care because their insurance coverage is inadequate.

The uninsured are diverse in many aspects and consists of those without insurance, those who cannot afford health insurance, those who can afford health insurance but choose not to, those without employment coverage, recent immigrants and those who are eligible for but not enrolled in government health funded programs (Texas Comptroller's Report, 2005).

Among the many concerns regarding the lack of health care coverage and access to a primary provider are the growing population trends and their effects on the health care systems such as the uninsured, and the underinsured (U.S. Census Bureau, 2004). Lack of health insurance is worse among the majority Mexican American population in Texas, which has higher rates of poverty. This is, in part, because Mexican Americans, the most prominent group in Texas and San Antonio, are more likely to work in service industry for employers who do not provide insurance (Wilson, 2005).

These uninsured issues combined with the current income and educational levels have placed an added burden on the health care system in the form of increasing financial costs known as uncompensated care costs. According to the Texas Health Institute, uninsured people pay about one-third of the cost of their health care out-of-pocket. Of the number that they are not able to pay, about one-third is covered by government programs, and the remaining two thirds is paid

by the insured through higher health insurance premiums. The Texas Heath Institute had estimated that the amount not paid by the uninsured for care in Texas would be $4.6 billion alone for 2005 and an estimated increase to $6.5 billion for 2010 (Texas Health Institute Report, 2006). Table 1 illustrates a break-down of the uninsured population in Texas.

Table 1

Demographics and Characteristics of the Uninsured in Texas

Percent of Texas Residents aged 0-65 who are Uninsured	27%
Characteristics of the Uninsured	
Employment	
Family member(s) working full time	72%
Family member(s) working part time	10%
Nonworking	18%
Age	
0-18	25%
19-65	75%
Sex	
Male	52%
Female	48%
Race/Ethnicity	
White	29%
Black	11%
Hispanic	57%
Other	3%
Income 0-199% of the Federal Poverty Level	71%
200% or more of the Federal Poverty Level	29%
Citizenship Status	
Native U.S. Citizen	68%
Naturalized U.S. Citizen	5%
Not a U.S. Citizen (Legal/Illegal)	27%*2006*

Source: Kaiser Family Foundation, StateHealthFacts.org, Texas: Health Coverage and Uninsured.

Employment Based Insurance in Texas

A study done in 2003 showed that Texas was ranked 48th in the nation, with only 52.4 percent of Texans having employment based health insurance coverage (Texas Department of Insurance, 2005). Additionally, most employees who are insured obtain this coverage through their jobs. Those in jobs which are not required to have health insurance coverage will often not seek coverage on their own. The report also revealed that most insurers and employers in the state have provisions that exclude the employers from providing coverage to part-time, contract, and seasonal workers (Strayhorn, 2005). The financial impact of these exclusions and the struggle of small business to provide health care coverage, have prompted Legislators to try to provide some resolution through two proposed bills, Senate Bills 541, and 10. Both bills if approved will allow small business employers to offer policies that limit health insurance coverage with certain mandatory services such as diabetes education and testing (Texas Legislature, 2005). This is important as small business employers struggle to provide health care coverage at a higher than average cost to their employees. This however is only one piece of the two part issue; the other is the need for additional funding of state funded programs.

The Texas Department of Insurance as well as the Texas Hospital Association (THA), and the Texas Comptroller's Report, identified in a report done in 2005 that the problem is not that employees choose to go without insurance but the issue is the actual jobs to which the employees are engaged. The report showed that the rate of employer based coverage is low because most Texans are employed in service industries which do not offer health insurance. The Texas Department of Insurance report (2004), identified the following trends which are intended to address reasons why Texas has such low health insurance coverage rate.

> .....Texans are more likely to work retail trade and service industries that are less likely to offer health insurance through the work place. Fewer Texans work in the manufacturing sectors, where employers are more likely to provide health benefits. Most insurers and employers in the state have provisions that exclude part-time, contract and seasonal workers from health coverage (p. 6).

Texas Code Red Report

To better define the uninsured in Texas, the Texas Code Red Report (2006), was included in this study to provide a definitive look at the uninsured in Texas. The Code Red Report illustrates the current high cost of care in Texas for the indigent and the underinsured as a crisis for Texas. Knowing that Texas is last in health care coverage is only one of the many points that the report addressed. The Code Red Texas Task Force addressed in the report the overall health conditions in Texas, the impact of the uninsured and the shortage of professionals to care for Texans. The findings and recommendations were provided to state and local leaders for action. The Code Red Task Force published its report (2006), that contained several significant findings as listed below.

> ..... Overall health condition of Texans is poor. Texas has the highest percentage of uninsured in the US. Texas cannot sustain the continued rise in Medicaid and state/county health care expenditures. Current trends in delivery of health care in Texas will inevitably exacerbate current problems: overdependence on emergency rooms for accessing primary care for the uninsured is the most expensive means of delivering care. Expansion of ambulatory services is an essential, more cost-effective means of health care delivery. Strategies that both control the cost of health insurance and ensure the most cost-effective delivery

> of health care access for all Texans are needed. Texas has not taken full advantage of available federal matching funds to reduce the burden of providing health care for the uninsured. The current county-based approach to delivery of health care in Texas is inadequate, and inequitable. There is significant shortage of health professionals in Texas- professionals that could reduce the cost of care of delivery of care to all Texans. Care for people with mental illness remains a major problem (chapter 10, p. 156-163).

The Task Force on *Access to Health Care in Texas: Challenges of the uninsured and underinsured* was issued in April 2006. This task force consisted of various professional institutions, including Baylor University, Texas A&M, the six health institutions and several others. The task force collected data, conducted research, evaluations, random polls and provided assessments and recommendations to policy makers. This includes the effects of the uninsured and the underinsured on the Texas economy. The report also addressed factors that affect health care coverage which included poverty levels, job choice and educational levels. The report concluded that most Texans above the 300 percent federal poverty levels have the means and opportunity to afford health insurance coverage, however they simply chose not to do so due to the high premium cost and co-pays.

In 2005, Blue Cross and Blue Shield conducted a study which indicated that people choose to avoid health insurance coverage because they feel that they are healthy, young, and think that there isn't a need for the coverage. However, studies by the Code Red Report Task Force indicates that while the above is true, some people choose not to obtain coverage for other reasons such as lack of awareness and the need to protect themselves of potentially high out of pocket costs to a laissez-faire attitude.

Immigrants in Texas

According to a study released by the University of California at Los Angeles, 12 metropolitan statistical areas were found to have higher than average uninsured rates. These areas had one commonality; they are all states with large populations of immigrants. The top five states are Texas, California, Florida, New York and New Jersey. Ironically, in these states, Hispanics have the largest share of moderate to low income. Specific to Texas where Caucasians are the minority, and Hispanics the majority, cultural differences also plays a major role on the decision to access care. The fact that most Hispanics are not curative care centered, health coverage is not viewed as a critical necessity. Instead, this population will seek care only when the pain or the medical dilemma is intolerable. Unfortunately it is this thought process that has led to unnecessary deaths and increased chronic illness and diseases.

In a report issued by the Institute of Medicine in 2004, there were over 18,000 deaths each year that were directly related to a lack of insurance (IOM, 2004). With increased educational awareness and additional funding of small business to provide coverage coupled with increase state health care programs this issue could be resolved.

Medicaid and Children's Health Insurance Program

The State and Federal Medicaid programs have a direct impact on health care facilities that provide care to the uninsured. In 2003, the Texas State Legislature was faced with the overwhelming need to cut budgets by $10 billion. As a result, Medicaid benefits programs were cut across the board, eliminating the Medically Needy Spend-down program, funding for the Medicaid and the State Children's Health Insurance Program (SCHIP). This adversely affected certain benefits such as hearing aids, eye glasses and mental health services (Hill, 2004).

The decrease in funding of these state programs also carries many obstacles to access. While it is true that the state programs do exist, the marketing of these programs to those who may be eligible is lacking. Many Americans who are eligible for existing government programs such as Medicaid and Children's Health Insurance Program (CHIP) may not be aware of the availability of these benefits. Conversely, there are some who find out through other avenues but choose not to enroll due to eligibility inconsistencies of the system. Another factor affecting people's decision to participate in the state funded government health care programs is the new eligibility procedures implemented. For example, residents enrolled in CHIP are required to have a re-determination of their eligibility every six months. As a result of budget cuts, the new eligibility policy governing assets have become more stringent, thus, families with more than $5000 in assets such as bank accounts, stocks and bonds etc, will no longer qualify for CHIP (DHHS, 2005). Additionally, income requirements are also barriers for eligibility of benefits. For example, the maximum income level for a family of two is $1100 per year to quality for children's Medicaid and $2200 for CHIP (DHHS, 2005). Figure 2 illustrates the poor state of Texans specific to children who are uninsured based on data from 1988 through 2003.

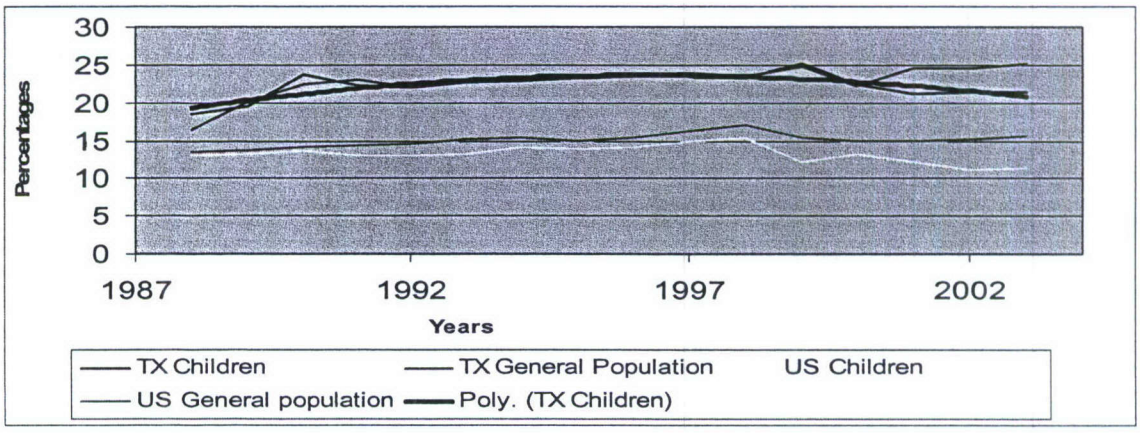

Figure 2: Comparison data of the number of uninsured children of Texas and the United States.

Source: Texas Code Red Report (2006)

Financial Impact

The high number of uninsured in Texas and across the United States is the main contributor affecting uncompensated care. Uncompensated care is defined as the health care rendered or services given for which payment is not reimbursed. This includes charity care, and bad debt. According to the American Hospital Association (AHA), charity care is treatment for which a hospital does not expect to be reimbursed. Bad debt is care or services provided with the intent of receiving payment for which the payment was not received. Bad debt occurs when hospitals cannot obtain reimbursement for the care provided. This happens when people are unwilling or unable to pay their bills (American Hospital Association, 2005). Uncompensated care excludes other voluntary or involuntary discounts or "reductions in revenue," such as underpayment from Medicaid and Medicare or discounts to private payers. Uncompensated care can also be defined for purposes of this analysis as the financial effects of providing care to the uninsured and underinsured.

The high cost of the uninsured is evident in the vast increase in uncompensated care dollars which is a burden that all Texans share. As tax-payers, providers, employees, and health care consumers, we are all affected by this financial burden. This is realized through monies allocated from taxes for government sponsored program such as Medicare, Medicaid, and CHIP. Locally, taxpayers are the main resource for funding public hospital systems.

A survey completed by Stoll and Jones assessed data from 2002-2003 specific to uninsured under age 65, showed that over 8.5 million or 43.4 percent of Texans under this age cohort were without health insurance for this period. As a result, when care was rendered, hospitals were left with an enormous uncompensated care bill for which payment was not

reimbursed. Figure 3 is a graphical depiction of the breakdown of uncompensated care cost in relation to Texas and the United States as reported in the Urgent Matters report (2005).

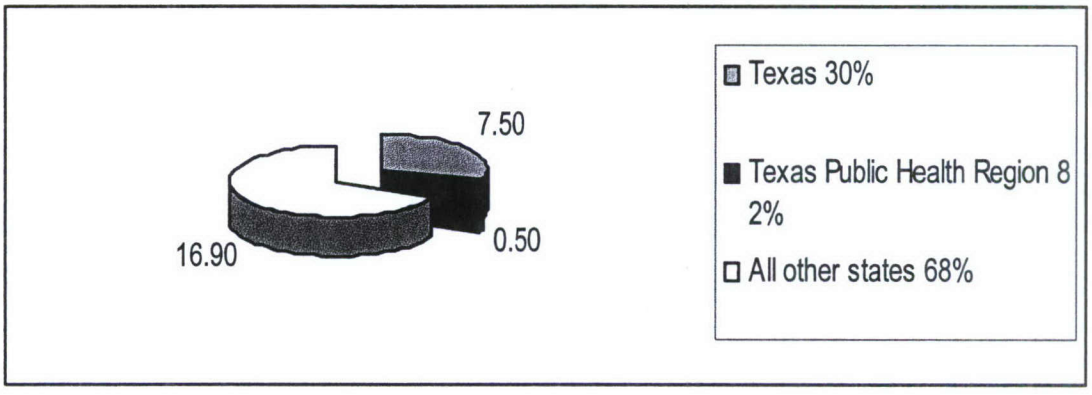

Figure 3: Total uncompensated care costs expenditures in billions, 2004.

Source: Urgent Matters Report (2005)

San Antonio, Bexar County

The city of San Antonio is home to the second largest city in Texas. Located in South Central Texas, it is also the largest metropolitan area reached after crossing the Texas-Mexico border. San Antonio is the core city with twenty eight counties both rural and urban in geography (Wilson, 2004). In the Greater San Antonio area in 2003, specifically Bexar County, San Antonio had a population of 1.5 million (Murdock et al., 2003). Current census data shows that Bexar County is predominately Hispanic at 56.1 percent, with 34.2 percent Non-Hispanic white, 7.2 percent African-American, and 2.5 percent other (U.S Census Bureau, 2004). Over 50% speak another language other than English in the home. This population has since increased and is further predicted to increase to 3.2 million by 2040 (Murdock et al., 2003). Two of the fastest growing groups during this 2003 period were the Hispanics and the 45-64 age cohorts. Specific to health insurance coverage, this population has the largest numbers of the working uninsured populous. Close to thirty percent of those uninsured are between the ages of 40-64 years of age

(U.S Census Bureau, 2005). The second largest group of uninsured is those who are seventeen years old or younger. The 18-24 age cohorts is listed as having at least sixteen percent of uninsured in San Antonio. Table 2 illustrates the uninsured population in San Antonio specific to the 18-64 age cohort.

Table 2

San Antonio uninsured by category

Category	Percent Uninsured, 2005
Age Group	
18-24	30.6
Household income	
w/income < $25,000	24.4
Individuals of Hispanic origin	32.7
Foreign-born non-citizens	43.6
Non-working individuals between 18-64 years of age	27.3

Source: Texas Hospital Association Report (2006).

For the over 65 age cohort, medical coverage is generally covered by government public programs such as Medicare/Medicaid programs thus minimizing the percent of uninsured in that category (Urgent Matters Report, 2005). To fully understand the demographics of Bexar County, a comparative demographic table is provided to show the differences in race as well as age for both the state of Texas and the city of San Antonio. Table 3 illustrates the demographic distribution for Bexar County, San Antonio. This is important as this provides additional evidence for a policy analysis which will provide health care coverage with access to a primary

care home to the groups that needs the most care and to whom care would be most beneficial and cost effective.

Table 3

Texas: Distribution of demographics for Bexar County and Texas

Select Demographics	Bexar County	Texas
Population	1409834	21215494
Race		
White	71.0%	74.70%
Black	6.80%	11.10%
Asian	1.80%	3.00%
American Indian/Alaska native	0.04%	0.40%
Other	20.00%	10.80%
Hispanic origin race	56.80%	33.90%
Age 18 and over	71.10%	71.40%
Age 65 and over	10.00%	9.60

Note: U.S. Census Bureau, American Community Survey (2002), *State and County quick facts, 2003, U.S. Census Bureau.*

Reasons for the uninsured in San Antonio are similar to that of the state of Texas. These include high poverty levels, high unemployment rates, no health coverage by small businesses, low education levels, employment in service jobs, and of most importance, a decrease in government funded programs. Studies by the Metropolitan Policy and Research Institute (MPRI) indicated that among the factors of high incidences for uninsured in San Antonio were mostly employed Hispanics with low education levels compounded by access obstacles. Access to

health insurance in terms of affordability is the main issue (Harris & Firestone, 2004). Research by the Urgent Matters report, 2005 indicated that unemployment was directly related to the uninsured. Results also indicated that this access to coverage also varies by age, race, ethnicity, job choice, family size and employer position just to name a few. Figure 4 illustrates both the financial and economical cause and effect of providing care to the uninsured in San Antonio.

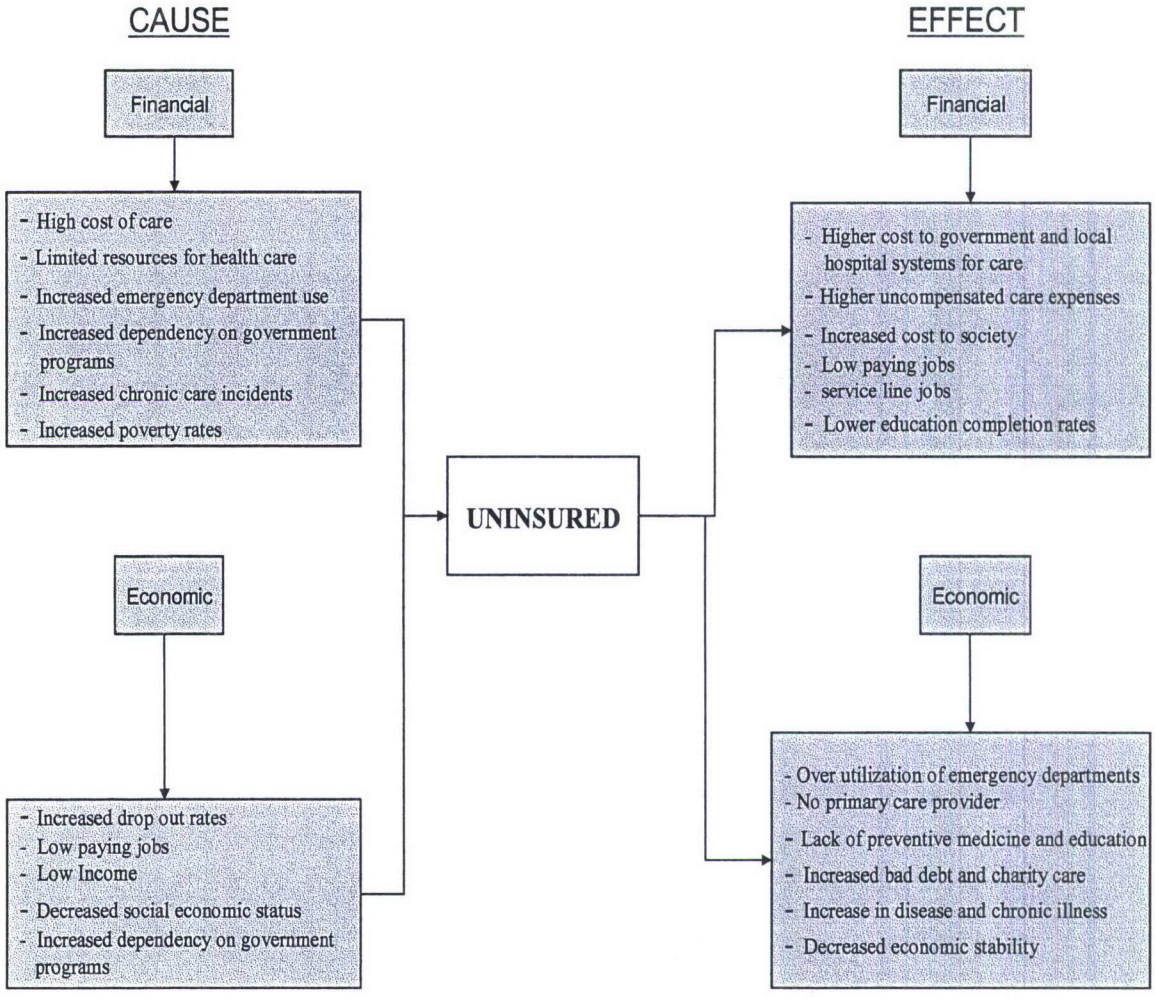

Figure 4.. The financial and economical effects of the uninsured in San Antonio.

The Greater San Antonio Hospital Council (GSAHC), is a not-for-profit advocacy organization which exists solely to assist local hospitals and other health care facilities in developing and supporting policies to improve the care and health of the residents of San

Antonio. The Council's mission is to provide an unbiased forum where facilities can come together for the common good of developing policies which local, state and national leaders can use to ensure the implementation of State programs to generate funding for health care. To assist the Greater San Antonio's Hospital Systems to cope with the increasing numbers of uninsured and underinsured, the Council has joined efforts with the local leaders and the business community to try and find a solution to the problem. This includes the implementation of several initiatives which will be discussed within the paper.

As mentioned before, the State and Federal Medicaid programs have a direct impact on health care facilities that provide care to the uninsured. Specific to Bexar County, it is predicted that the county will loose a substantial amount in funding due to Medicaid and SCHIP cuts similar to the cuts realized in the 2004-2005 budget of $153.2 million. Additionally, stringent eligibility requirements were also implemented for access to these services. As a result, the SCHIP program has seen a decrease in people who are eligible for these programs. The program which was initially originated as an adjunct to existing programs to provide an avenue for people who could not afford health insurance has now become a cumbersome initiative with many barriers and obstacles which have discouraged many from applying. One such obstacle is the change in income requirement for eligibility. For example, the SCHIP income eligibility limit for recipients is 200 percent or $40, 000 for a family of four in Texas (Code Red Texas, 2006). This is a change that has resulted in the ineligibility of many needy families for services. Thus fewer applicants are able to quality for these programs.

This reduction of funding combined with the current changes in eligibility requirements for the state funded programs, will lead to an even higher percent of children and parents without coverage. Unfortunately, the problem does not end there, due to the reduction of payments for

reimbursements to providers by the legislature, additional barriers have developed. These include the absence of providers who are willing to care for state funded patients and the indigent. Providers now have to balance providing care without appropriate reimbursements while facing the financial challenges of maintaining a viable practice. The direct impact on Bexar County hospitals in lieu of this employer non-availability of health care coverage, the decrease in funding in State and Federal programs and the decrease in provider reimbursement have resulted in a median wage economy with poor health choices and a struggling economy. Additionally the financial impact has resulted in over $29 million in health care costs, and continued increases in uncompensated care cost and bad debt operating costs to health care facilities (Texas Comptroller's Report, 2005).

Uninsured in Bexar County, San Antonio

According to Guyer & Mann (1999), Texas has the highest proportion of low-income employees without insurance coverage at 61.1%. Budetti, Chikles, Duchon, and Schoen, (1999) reported that among workers with annual incomes below $35,000, 32% were uninsured and 37% went without needed medical care. While younger, low-income adults, particularly African Americans and Hispanics, have the highest uninsured rates, half of all low-income uninsured adults are white-collar employees (Holahan & Brennan, 2000). The median household income in Bexar County in 2004 was $39,694 compared to $41,759 in the rest of Texas (U.S. Census Bureau, 2004).

Economic impact on Bexar County

Although businesses are developing in Bexar County, the unemployment rate continues to rise due to lack of qualification for job placement (GSAHC Report, 2006). According to the San Antonio Chamber, the unemployment rate in Bexar County has been increasing over the past

four years and has since risen to 5.1 percent in the first quarter of 2003 alone. This had a direct impact on the cost of care, specifically the uncompensated care costs. Another group that had a major impact on the high costs of care is the underinsured who are employed but are not provided adequate insurance coverage by their employers (GSAHC Report, 2006).

Income is also a major contributor to the increase in uncompensated care costs in San Antonio. Since employment does not guarantee health insurance coverage, low income employed parents are at high risk of being uninsured because they have limited access to publicly-funded insurance, but often hold the types of jobs in which their employers do not provide insurance coverage (Acs et.al., 2000; Holahan & Brennan, 2000).

Small businesses

Due to the high cost in insurance premiums, small businesses are having difficulties providing coverage for their employees. Small businesses face higher costs because they cannot create a large pool from which they can allocate funds to individually insure their employees (Texas Department of Insurance, 2005). In businesses with few employees it is extremely difficult to justify the coverage for employees based on the cost to the company and the return on the company's individual investment for each employee. According to a newsletter released by the Texas Hospital Association, on a national level as of 2005, some 98 percent of large firms offered health coverage while only a small percent of small firms offered coverage. This small 59 percent equated to only 3 in every 199 workers. In 2001, the Texas Department of Insurance conducted a survey to collect information from small businesses on what the specific reasons were in providing health care coverage to its employees. The Texas Department of Insurance (2001) survey report which was published in 2005 had the following significant findings, which is key in determining how to address this deficiency.

.....The primary reason employers do not offer insurance is still because it is unaffordable; 54 percent of employers reported they can afford $100 a month or less per employee for health insurance premiums; 34 percent can pay $50 or less, and 14 percent would not purchase insurance at any cost. 81 percent of employers believe employers should provide insurance if they can afford to do so. In a separate question, however, only 7 percent indicated they believe employers are primarily responsible for assuring people have coverage. 41 percent believe individuals are themselves responsible; 32 percent said the federal government is responsible, and 12 percent believe state governments are responsible. Of those employers who currently offer insurance, 18 percent are very likely to discontinue coverage within the next five years; 24 percent report they are somewhat likely to do so. 69 percent of employers said it is more important for government to focus on improving access to affordable health insurance than improving access to affordable health care, while 26 percent said that improving access to affordable health care is more important. When small businesses do offer coverage, employees often are unable to afford their required contribution. This is particularly true of "family coverage." Workers in small businesses often must pay a higher share of the premium cost than workers in large firms. The average cost of family coverage for small businesses is more than $11,000 a year per-employee, and many workers must pay 50 percent or more of the cost. For low wage workers, this expense is truly unaffordable. A significant decrease in cost would be necessary in order for many of these workers to "take up" the health insurance that is available to them (p. 54).

Recent policy proposals from the Code Red Report (2006), and the Urgent Matters Report (2005), suggests the need for government intervention to assist small businesses to have the ability to provide affordable health coverage to the employers. Awareness of the gravity of the situation has resulted in local health systems throughout Texas in conjunction with the Texas Hospital Association, to propose a formal policy initiative for legislative approval.

As mentioned before, the population demographics has tremendous impact on the proportions of people uninsured. In Bexar County where there is a higher population of immigrants especially with a higher concentration of Mexican Americans, the challenge is greatest felt. Immigrants often lack access to insurance, which is compounded by other factors such as language skills, knowledge of health resources, and poverty (Code Red Report, 2006). These factors affect the receipt of proper health care. In addition to the existing problems in Bexar County, the effects of hurricane Katrina have augmented the situation as several displaced families relocated to and have remained in San Antonio to date. This has posed a financial and economic burden to the already struggling economy of San Antonio.

Although it is thought that the immigrants and the relocated families affected the increase in the number of uninsured tremendously, the Code Red Report (2006), indicated otherwise, reporting that the uninsured in Bexar County (with the largest population of uninsured) is predominately the middle-income workers and not the poor. The burden then is providing care for this working class who often make too much income to qualify for assistance and too little to afford the care on their own. The burden to provide care for this sector rest with the local hospital facilities.

Barriers to care in Bexar County

Bexar County has four local health systems: the Bexar County Hospital District, Christus, Baptist, and University Health Care Systems. These organizations take responsibility for the indigent patients in the county, but the Bexar County Hospital District in San Antonio cares for three times more of the uninsured than the rest of the local health systems combined. Despite the variation of systems, there are consistent themes shared by all in the form of barriers to care.

Bexar County faces several barriers in providing care to the uninsured and underinsured. Some of the barriers include the cost of care due to low reimbursement rates, non-payment for services, high uncompensated costs, and lack of specialty providers who are willing to provide care to this high cost category of patients. Other barriers include access problems and transportation issues specific to rural areas. These issues are all at the forefront of the ongoing quest by the local San Antonio Health Care Systems, the Greater San Antonio Hospital Council and local leadership to include the County Judge, the City Mayor and the Greater San Antonio Chamber, to try to provide a viable solution to this problem. Of great importance is the recruiting and retaining of qualified primary care physicians to participate in providing care to the indigent both in the rural and urban areas.

Rural San Antonio continues to experience many barriers in accessing care. One of the barriers specific to rural areas is the geographic barrier. This geographical barrier has caused a physician maldistribution effect that has resulted in very few doctors living in and practicing in most of the rural areas where most of the uninsured resides (Code Red, 2006). These barriers coupled with transportation issues and low incomes have added to the already high incidences in chronic care cases and the growing need for preventative care programs. These geographic barriers have also caused an increase in chronic care, communicable diseases, and outbreaks. In

addition, changes in welfare eligibility standards have impacted uninsured rates. About 33% of women who leave welfare are uninsured within six months of leaving, and after twelve months close to 50% have no health insurance (Hollohan, 2000). These issues combined with the mentioned demographics and socioeconomic barriers, have led community leaders to seek a safety net to try to meet the increasing costs of uncompensated care.

Issue for discussion

San Antonio's Bexar County has been impacted by the increase in uninsured and underinsured due in part to the high numbers of small business without health insurance coverage and the state of Texas continued decreases in state health covered programs.

As the cost of providing care for the uninsured continues to increase, local state and national leaders have become involved with this problem, working as a unit to try to bridge the gap in the cost of health care coverage. This is due to a general increase in the population as well as the growth in the number of individuals who are employed but uninsured also the many limitations and barriers present in providing care to the working uninsured. The County Judge has been working with the Hospital Systems, the Public Health Systems and the local Hospital Council to provide health care awareness to the community and to encourage preventative care.

Since the County Judge is the approver of any tax increase this is an important facet to policy implementation and solutions as hospitals try to provide care while loosing income. In 2001 the County Judge initiated a Health Care Capstone summit in which all the leaders in health care were invited to attend an awareness brief to discuss health care issues. Here leaders dialogued about growing concerns such as the uninsured, uncompensated care cost, the need for additional funding for government programs, the educational impacts as well as the health impact on the city.

On September 15, 2006, the Judge had a five year follow-up with action items to get the health care community on track. The local city members, Mayors, both past and present, as well as the local hospital systems rural and non-rural Chief Executive Officers, Chief Financial Officers and Chief Nursing Officers and the Deans of the six nursing schools were invited as a part of the San Antonio action team. Concerns ranged from the decrease in Medicare reimbursements, to the overcrowding of Emergency Departments (ED), to the need for the community to assist small business to provide health coverage. Furthermore, information addressed as a quorum is scheduled to be discussed in Austin, the State's Capitol and then in Washington DC with the State Senators and elected Representatives. The goal is to provide initiatives and action items for policy makers to use to institute programs to ensure access to care for residents of San Antonio.

In the meanwhile, in a concerted effort to correct these deficiencies, local leaders headed by the Greater San Antonio Hospital Council, have developed and implemented several local initiatives to provide some relief to local hospital systems from the financial and economical burden of providing care to the uninsured. This burden includes attempts to decrease the uncompensated costs to the hospital system and shifting them to the state and federal level. These initiatives includes the local county education awareness and prevention program, the local healthcare collaborative program, the local safety net program, the University Hospital Carelink program, the County Indigent program and the Methodist indigent care program. These program initiatives are significantly important to San Antonio and its economy as a healthy population results in positive outcomes for the community, the economy and the state. For purposes of this policy analysis, the importance of one specific local initiative, the Carelink program will be discussed in detail.

CareLink

Unique to San Antonio, the CareLink program is a health care payment program plan which was instituted to offset the cost of care and to reimburse providers for attending to the uninsured. The CareLink program was implemented in 1997 by University Health System and currently serves over 61,000 individuals in Bexar County, most of whom have income well below the 150% poverty levels (Urgent Matters Report, 2005).

The CareLink program is a membership program where members can receive services in 25 locations throughout Bexar County. The purpose of Care Link is to attempt to provide a medical home for the indigent population to allow for continuity of care and a long term relationship. Care is provided at a lower cost through participating providers and integrated systems. There are specific requirements in place which includes an income limitation that dictates eligibility. Based on this scale, the family's income must fall below the 200 percent family poverty level. According to a recent report released by the Safety Net Urgent Matters Report (2005), CareLink enrolls less than 15 percent of the uninsured in San Antonio due to funding restrictions which still leaves a large number of residents without coverage. It is this group that has caused the financial effects of an increasing uncompensated care tab. Table 4 illustrates the monthly income eligibility requirements as discussed below.

Table 4

Monthly income qualification chart for CareLink, 2005

Family Size	Total Household Income
1	$1,633
2	$2,200
3	$2,766

Table 4 (*continued*)

Monthly income qualification chart for CareLink, 2005	
4	$3,333
5	$3,900
6	$4,466
7	$5,033
8	$5,600

Source: Urgent Matters Report (2005)

The University Health System which is the sole public hospital in the county cares for the vast majority of uninsured and indigent patients. The other local systems have also experienced a remarkable increase in their indigent care; however, it is University Health Systems Hospital (UHSH), that has had to bear the grunt of the costs. It is this enormous increase in uninsured care that motivated the University Hospital System to institute the CareLink program.

Although CareLink is an all-encompassing indigent program, barriers are its greatest enemy. To date there is a shortage of specialty physicians who have agreed to be a part of the program. This has led to delay in care and long appointment wait times. Both the inpatient and outpatient mental health services are in need of additional providers. This lack of providers committed to care for the less fortunate has contributed to the overcrowding crisis in the Emergency Departments. Table 5 illustrates the relative rates for ED visits at UHSH.

Table 5

Demographic characteristics of ED visits in Bexar County, 2006

Category	*Percentage*

Table 5 (*continued*)

Demographic characteristics of ED visits in Bexar County, 2006	
1. Race	
Black	6.8
Hispanic	67.4
White	23.0
Other/unknown	2.7
2. Coverage	
CareLink	16.5
Commercial	9.8
Medicaid	20.8
Medicare	7.5
Other	3.6
Uninsured	41.8
3. Age	
0-17	9.6
18-64	85.5
65+	4.9
4. Gender	
Female	56.2
Male	43.8

Note: Data taken from the George Washington University Medical Center Urgent Matters Report (2005), provided by University Hospital emergency department.

Government programs in Bexar County

Government programs are also available however, only about 11 percent of all eligible Medicaid and SCHIP persons are covered by public insurance. Reasons for this low number includes many issues such as increase eligibility requirements, access to services, lack of transportation and the absence of marketing to the underserved. The following table is a snapshot of the Medicaid and CHIP enrollment data for Bexar County. These numbers when interpreted means that a large portion of residents are without coverage leaving the cost of caring for this uncovered group, on the community especially, the local hospital systems.

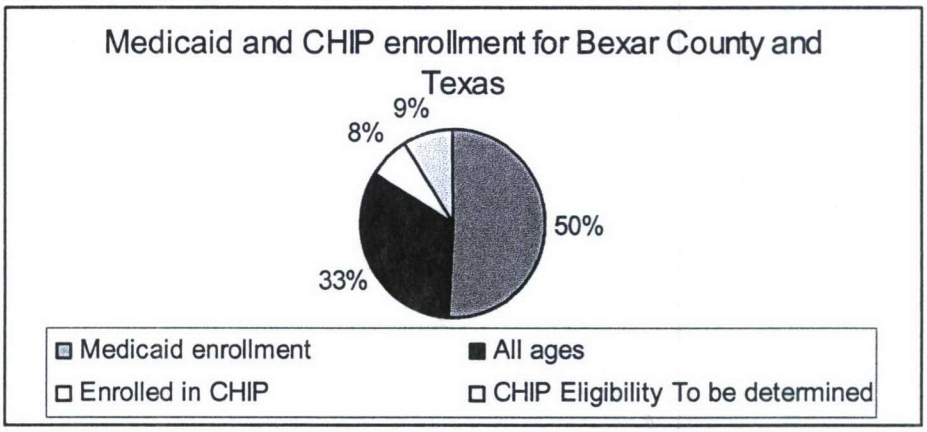

Figure 5: Bexar County and Texas Medicaid and CHIP enrollment by percentage.

Source: Texas Code Red Report (2006)

The need exists to provide alternatives for the Greater San Antonio Hospital Systems and its neighboring organization to allow them to continue to provide care to those in need without further financial loss in the form of uncompensated care costs. Any alternatives proposed must result in increased access to care for the uninsured to ensure a healthy population, and to shift the cost of care from the local hospital systems to state and federal subsidized programs. The next section will present alternatives that the Greater San Antonio Hospital Systems can utilize to increase access to care for the uninsured, increase provider participation in providing care to the uninsured in the form of higher provider reimbursement rates and avenues to capitalize on available government funds to increase health care coverage for the uninsured and the indigent in San Antonio.

Alternatives

Alternative one – Reform of Texas Indigent Care Programs and Requirements.

In the state of Texas, it is the responsibility of each county to care for its indigent population including the uninsured and the underinsured. By law, all counties must establish a County Indigent Health Care Program as defined in the Texas Indigent Health Care and

Treatment Act. The State Act requires that all County Indigent Health Care Programs provide all the necessary basic health care coverages to the indigent regardless of race, creed or color. Since the State of Texas has already established minimum income eligibility standard of 21% of the federal poverty level (FPL), this County Indigent Health Care Program would follow the state guidelines, thus considering all persons in Bexar County who are below the 21% FPL to be indigent thus meeting the eligibility requirements for care.

This County Indigent Health Care Program will be a revision of the current County Indigent Program, which is maintained by University Health System. This revision will be instrumental in cutting costs to the local community and patient as well as decrease the uncompensated care costs and bad debt incurred currently by the local hospital systems. By ensuring strict eligibility requirements, Bexar County will be able to take care of its indigent while disqualifying out-of-county patients' access to these services as one as to be a resident of Bexar County in order to quality for this program. This will also decrease unnecessary costs to the hospital systems in Bexar County and will allow services to be provided to only those who are truly in need and have met the County requirements. It will also ensure that funding is spent effectively and that access for services is timely and efficient.

Alternative two – Restoration of Medicaid Medically Needy Spend-Down Program

In 2003, the Medically Needy Spend-Down Program was eliminated due to pressures for budget cuts at the legislative level. The program was a resource to mothers who have medically needy children but could not afford the necessary medical treatments to improve their health (DHHS, 2005). Restoration of this program will allow working poor parents with increasingly high medical bills to qualify for and receive Medicaid during illness or injury without

disqualifying them because their incomes are slightly higher than the regular mandated Medicaid income limits.

The loss of the program has shifted costs of caring for the sick, injured, uninsured and working poor to local systems. According to the Department of Health and Human Services (DHHS), the loss of the Medically Needy program for 2003 alone has resulted in a $1.1 million per month decline in revenues to the local public hospital as well as notable financial losses to other hospitals. Restoration of the program will provide a safety net for the medical community to those eligible for services. Restoration of the Medically Needy program at the state level will allow for the availability of over $204 million in state funds with matching Federal dollars of approximately $300 million (DHHS, 2005). This will provide financial relief to the many hospitals and their systems especially in San Antonio Bexar County, that have been experiencing a financial loss due to a the elimination of the program which had shifted medical costs from the state and federal levels to the local providers and hospitals. Funding for this program from the state and federal levels as well as from the county will enhance the ability of the hospitals to provide effective care for its population. Locally generated revenue will be used as general revenues to defray the cost of care to the medically needy.

Alternative three - Reformation of the State Medicaid and CHIP programs.

Medicaid and the Children's Health Insurance Program (CHIP), provide health insurance coverage for two key cohorts: the elderly, and children under the age of nineteen. Once eliminated, the Texas legislature restored partial eligibility to the affected population. However, the legislature failed to restore full reimbursement to providers who were apart of the Medicaid Adult Medically Needy Spend-Down Program. Reformation of this program to include full

funding and reimbursement rates will allow more of the working poor to afford health care and the ability to access care without having to choose between health care and daily living needs.

An added incentive will also be accomplished in the form of offering employers the opportunity to buy in to the Medicaid and CHIP coverage for their employees. This will be beneficial to the employees of small businesses, the community and the economy. Reformation of this program will be useful in creating an environment for providers to be able to care for patients without taking the financial loss for doing so.

The effects of this reformation will encourage a healthy population with an emphasis on educating the public about the advantages of proper health care. It will further decrease the over expenditures in emergency department visits for non-acute care needs and extensive uncompensated care costs.

Alternative 4 – Expansion of the CareLink Program

San Antonio like other cities across the country is faced with the difficulties in sustaining the mission of providing health care to the uninsured and the low-income populations of Bexar County. San Antonio's Bexar County is the hub of the community's safety net health care systems with its four major hospitals systems. University Hospital, the leader in care to the indigent, implemented a CareLink system that has since 2005 served collectively across the systems, 160,448,000 persons with 58% being uninsured. As the population continues to increase however, it has now become necessary to expand the CareLink program across the city to allow more working poor to access care.

Developed specifically for the working poor, the Carelink program has allowed access to healthcare coverage to thousands in San Antonio. Still there is room for expansion of the program to allow for maximum healthcare coverage and access. This expansion will be two-fold.

First, expansion of the program to allow more working poor to qualify will be necessary to allow maximum access to healthcare, second, expansion of the program to all participating providers with guaranteed increased reimbursement rates, will allow for increased access to care for the patients and availability of participating providers. This two-fold expansion approach will allow medical homes for patients thus ensuring continuity of care and the foundation for preventative care with patient buy in and provider patient education. This will also ensure the assignment to medical homes without additional construction costs for new facilities and additional staffing, easing an additional financial and economical burden from the hospital systems (Urgent Matters Report, 2005).

Alternative 5- Status Quo

San Antonio Bexar County has several viable options one of which is status quo. In order to sustain status quo, the county need not implement any alternatives and will not address the issue of the financial and economic burden of the uninsured and the indigent in the Greater San Antonio Hospital Systems.

Criteria for Evaluation of Alternatives

Criteria for evaluating the proposed alternatives and the projected outcomes are based on evidence based initiatives used by several health care organizations to include the Institute of Medicine Committee on the National Health Care Quality and the Joint Commission on Accreditation of Healthcare Organizations. These criteria will draw from Donabedian's theory of structure, process and output and the Anderson behavior model. The Donabedian theory is a qualitative approach model used to assess quality in healthcare. For purposes of this policy analysis it will be used to assess the quality associated with the availability of healthcare coverage and the effects of the lack of providing the care. The Anderson behavior model like the

Donabedian theory is another approach used to assess and analyze how healthcare is accessed and utilized. To date it has been used extensively nationally and internationally as a framework for utilization and cost studies of general populations as well as special studies of minorities, low income, children, women, the elderly, oral health, the homeless and the HIV-positive population (IOM, 2004). For purposes of this policy analysis, this model will be used to assess how healthcare is utilized as it relates to access, cost and barriers to patient centered care.

The standard used to evaluate the current lack of access to healthcare coverage for the uninsured and the indigent in the Greater San Antonio area will be access, cost, and barriers to patient-centered care. These measurements will allow a broad approach in addressing the lack of health care coverage with access to a primary care provider as well as the financial impact on the local systems. It will further provide an in-depth look at the issue for possible policy revisions.

Access to primary care

Access to health care is an important piece in solving the uninsured puzzle. Policies focused solely on providing health services to the homeless or other indigent populations are not enough to meet the health care concerns in San Antonio. In a study done by Collins, Doty, and Davis (2004), the study indicated that there is a direct relationship between access, cost, choice of health care and basic daily needs. This means that for the working poor it is often the choice between affording the care and paying their rent or electricity. Access then will need to be addressed in terms of having the means to be seen by a provider or have a provider based home to receive not only necessary care but preventative care and education.

Access is defined in health care as "the opportunity or right to receive health care". However to the average patient, access to care means that coverage is available and affordable for everyone. For purposes of this policy analysis access to primary care is aimed at managing

patient care through their primary care providers to ensure continuity of care by ensuring that coverage is available and affordable and promoting a healthy lifestyle through increased access to healthcare services and education awareness.

The inability to access care in San Antonio is widespread due to the recent budget cuts in funding for the Medically Needy and the CHIP programs. Further deficiencies exists as the local initiatives and the Care Link program can only enroll about 15% of the working poor due to its budget constraints. Thus, leaving an extensive gap in access to care for most of the uninsured and the working poor who are not in that 15% covered entity.

The deficiency in access to care is also attributable to the lack of providers who are willing to take a possible financial risk in caring for the uninsured and the working poor. Recent cuts in reimbursement rates by Medicaid and State funded programs have also caused providers to limit access to their services. This has resulted in an increase in the number of patients who cannot access providers for care and the over utilization of emergency rooms for primary care.

Costs

In proposing any alternatives for change, cost becomes the major encumbrance. There are the varying definitions of cost as it relates to health care and those who fund it. It is because of these variations that it is necessary to define the meaning of cost. Generally cost is defined in the Webster's dictionary as "the amount or equivalent paid or charged for something" or "in terms of price, the outlay or expenditure (as of effort or sacrifice) made to achieve an object". The dictionary also gives a second definition, "loss or penalty incurred especially in gaining something". Since cost is tied to all areas of care to include organizational costs, economic cost, state cost and federal cost, it evokes the interests of all those who are in a position to affect change. For purposes of this paper the ultimate result of considering cost will be to reduce the

financial impact of the uninsured specifically the working uninsured and their uncompensated care cost by 50%.

The current increase in health care cost as published by the Texas Comptrollers' office lists the current cost for the United States as 15% of the Gross Domestic Product (GDP). This high cost of care is crucial to hospitals and employers as well as leaders at the local, state and national levels. The Texas Association of Business (TAB) published a report in 2002 which indicated a decrease in the number of small business employers who offer insurance to employees due to the high costs. The Texas Department of Insurance confirmed that in 2004, surveys reported that there has been a shift in cost of providing health care in larger organizations where employers are now shifting the cost from their check books to that of the employee and the local public organizations. This behavior has become prevalent and employees are realizing higher premiums, deductibles and co-payments.

Another area of concern is the cost of not providing health care to the uninsured, the indigent and the working poor. To date the cost of not providing care outweighs the cost of providing care on all levels. The Code Red Report details the growing concern of care being rendered at overcrowded emergency departments due to lack of a primary care homes. The cost to the facility alone is far more substantial not to mention the economic cost of having an unhealthy city with increased absenteeism from work and school.

All these factors affect the economy as people who are unable to work are not able to pay taxes and contribute to the economy. Likewise, children who cannot attend school due to frequent illness from poor health choices, loose necessary hours of education and are often left behind or minimally graduate to odd jobs in the society. These uneducated or undereducated populations place a strain on the already struggling economy. This correlates with the structure,

process, and output effect of the Donabedian's theory. Poor structures (choices in health care due to lack of coverage) leads to a broken process in the form of absence of preventative care and a healthy life style. This in turn leads to poor output or outcomes in the form of an unhealthy nation.

Barriers to Patient centered care

The Healthcare Research and Quality Act of 1999 have seven distinct measures which are components of quality medical care used to address delivering health care. These seven measures are *effective, safe, timely, patient centered, equitable and efficient care*. Patient centered care for purposes of this paper will address the specific needs of the local population and the uninsured in terms of the barriers associated with access to healthcare for the uninsured population.

The preliminary definition of patient centered care as set forth by the Institute of Medicine Committee on the National Health Care Quality Report is defined as "*Health care that respects and honors patients' individual wants, needs, and preferences, and that assures that individual patients' values guide all decisions*". This means that for Bexar County providers rendering patient centered care, must not only focus on the immediate health care needs but on continuity of care for all health care needs as well as long term health needs, patient desires for care, patient cultural differences, advance directives choices, care choices and preventative health care with an educational approach. However, due to the lack of participating providers in San Antonio who are able to relate to both the cultural and medical needs of the population, a barrier exists. In addition to this provider barrier are the various barriers of care as discussed earlier to include transportation to and from the healthcare facility, low income, and language barriers. Therefore, the need exists to ensure that patient education and provider education are in

practice to guarantee positive health outcomes. This will allow providers to collaborate with each other (specialists and primary care) to provide the best care that is specific for each patient need. For the uninsured and the Medically Needy Program recipients to include CareLink and CHIP, patient centered care will allow them to communicate their distinct needs and concerns about their health care thus reducing barriers to care. This approach will allow a collaborative effort in meeting health care needs and at the same time provide care in a setting that is appropriate, patient centered and barrier free.

The results of a barrier free patient centered care approach will be a positive move in the direction of meeting the objectives of a healthy population. This will be in compliance with the Healthy People 2010 initiative which emphasizes the importance of preventative care and education for a healthy lifestyle. By removing as many barriers as possible through local outreach programs to include availability of transportation and subsidized programs, this will ensure access for the uninsured and the indigent population that will ultimately result in timely accessible patient care with a higher potential for continuity of care, educational and preventative awareness.

The Anderson's Behavioral Model best explains healthcare utilization as it relates to the patient centered care approach. This model explains patients' reasons for seeking healthcare. The choice of selecting or seeking health care according to the Anderson Behavioral Model is based on predispositions (demographics, attitudes), enabling (by family and community), and need (either self assessed or by the clinician), all the variables which must be addressed to ensure that a patient centered care approach is achieved.

Criteria for Matrix

Access

Access to healthcare coverage. The program selected should allow for maximum access to care to primary care providers and specialty provides for care.

Access to primary care providers. The program selected should ensure a primary care provider for all care to ensure continuity of care.

Emergency department utilization. The program selected should decrease the over-utilization of emergency departments for routine non-acute care episodes.

General healthcare utilization. The program selected should allow for healthcare utilization when necessary and encourage preventative care approach to decrease unnecessary visits.

Preventative healthcare education. The program selected should embrace a preventative care approach stressing patient education and prevention. The program should have funding set aside specifically to allow for patient education.

Individualized Patient Centered Care

General healthcare coverage. Healthcare access does not always equate to healthcare coverage. To ensure that patients are efficiently cared for, the program selected must ensure that healthcare coverage is accessible to the patient for individualized care when needed from providers.

Healthcare utilization rates. Access to care does not equal an automatic increase in healthcare utilization; therefore the program selected must be easily accessed by those eligible and marketed adequately to ensure awareness of the services. According to the *Code Red Report, 2006,* access to any healthcare program for the uninsured and or indigent will more than likely result in an initial increase in utilization rates, however, with effective continued care this will taper off to usage that is necessary for positive healthcare outcomes.

Cost

Cost to the healthcare community in the form of uncompensated care costs, charity care costs and bad debt. The program selected should minimize uncompensated care costs to the healthcare community.

Cost to small business employers: The program or programs selected should provide avenues in the form of tax breaks or pools to allow small business employers to be able to provide affordable healthcare coverage.

Cost to federal and state government which provides healthcare to the population. The program selected should allow for budget flexibility in order to provide care to those eligible without additional costs to the government and or state.

Cost to individual. The program selected should only nominally change the costs of care to the individual and in cases where these are the indigent no change in costs at all.

Cost to County. The program selected should decrease the current cost to the county and its local initiatives in providing care to the uninsured and indigent.

Barrier free patient centered care

Availability of participating providers. The program selected should allow for an increase in participating providers with a fair reimbursement rates to allow or maximum participation for effective patient care.

Availability of primary care providers for healthcare home. The programs selected should allow for long term provider patient relationships in the form of a long term healthcare home. This will allow for continuity of care for the patient and will foster relationships between the providers and their patients who are familiar with their health history, culture, diversity and ethnicity.

Projection of Alternative Outcomes

Reform of Texas Indigent Care Programs and Requirements

The County has the responsibility under Texas law to provide basic health care services to eligible residents whose monthly net income does not exceed 21% of the Federal Poverty Guideline (FPG). Given the high number of uninsured in San Antonio (25%), reforming the program in the form of eligibility requirements and increased funding, would not only provide health care services to qualified residents but would also allow county hospitals expansion of their current operations to provide additional services. This would allow for basic primary care needs to be addressed while promoting optimal care for the indigent population.

The county has the final authority to increase the monthly income standard for eligibility, thus, reforming the eligibility requirements from 21% to 50% would enable the indigent to get their basic healthcare needs met while allowing the county to maintain its status to qualify for state assistance. This would result in zero additional cost to the state. The cost to the county would minimally increase as the county is financing most of the additional cost through local county taxes. However, since the county has a safety net, the hospital organizations through local initiatives have managed thus far to defray the cost to the taxpayers in order to provide services to the indigent.

In terms of utilization, this reform would result in an increase in healthcare usage initially however, over time as the basic needs are met, this boost in utilization rates will subside. This ability to access care would improve the general health of the indigent while empowering them through education and prevention awareness to maintain a healthy lifestyle. Though effective, this reform would also allow maximum access for basic care by the indigent however the need for follow-up care with primary and secondary providers for continuity of care is still lacking.

Although it provides an avenue for basic healthcare to the indigent it is not a permanent solution to the increasing need for a permanent program which would allow for a primary healthcare home ensuring timely, effective, efficient individualized patient centered care.

Restoration of Medicaid Medically Needy Spend-Down Program

Full restoration of the Medically Needy Program would increase access to healthcare coverage for the targeted population. This full restoration would also allow those eligible an avenue to get their healthcare needs met while taking care of catastrophic medical bills. While it is true that utilization would increase this is a temporary program therefore the increase would only be present for the period of eligibility.

Although a small piece of the uninsured pie, if left alone, this particular cohort would become an added burden to taxpayers of the state of Texas. The cost of care would automatically fall on the tax payers and the healthcare organizations in the form of very expensive uncompensated care costs. Full restoration of the Medically Needy Program then would provide an avenue of relief for healthcare organizations and would result in an additional $517.7 million over fiscal 2006-2007 to assist in offsetting the cost of caring for the uninsured.

Although effective in meeting its goals to assist with healthcare coverage for those patients who have become inundated with costly medical bills due to ongoing chronic illness, this program is not a long term solution as it is eligibility sensitive with limited time constraints. As a result, healthcare utilization, access to a provider for continuity of care as well as preventative and educational services would realize a temporary increase over the eligibility period. It is however the cost of proving the care that is long-term.

Reformation of the State Medicaid and CHIP programs

Reformation of the State Medicaid and CHIP program is not a new proposal. Since its original cuts in 2003, the Texas Comptroller as well as other healthcare advocates have been pleading with government to fully restore the program and to eliminate all proposed cuts in order to sustain it. The fact that 20% of Texas children are without healthcare coverage is enough evidence to rally for full restoration of the program. In addressing cost, it would be beneficial for the state as it will be able to capture federal funds which is currently unclaimed by Texas. These funds would allow healthcare coverage to more Texas children who are eligible under the program.

According to the AHA and the Code Red Report, in 2003, over one-third of Texas children went without healthcare which resulted in increased absenteeism from school, low high school graduation rates and increase chronic illnesses. This neglect in coverage has also financially affected the economy through over-utilization of emergency departments and increases in bad debt to the uninsured.

Full restoration of this program to include enrollment waivers would allow access to healthcare coverage to the population that is most in jeopardy should they continue on without taking care of their unmet healthcare needs. Healthcare utilization would increase with enrollment and eligibility however the long term financial and economical impact would decrease substantially resulting in a healthy generation with positive health outcomes. Although the cost to the state would realize an initial increase with eligibility and enrollment waivers, with full restoration it would realize more in federal dollars as compared to the current state dollars. This increase in matching dollars would allow for each child to have access to a primary

healthcare home and ensure continuity of care while enrolled. This would decrease the cost to emergency departments and the taxpayer.

Expansion of the CareLink Program

Expansion of the CareLink program to all participating providers within the county at a reasonable reimbursement rate, will allow more providers the ability to participate in a local initiative to provide care for the working poor. For the patient, this expansion would allow them increased access to care across the county. Additionally, it would allow medical homes for these working poor patients thus ensuring continuity of care and the foundation for preventative care with patient buy in and provider patient education.

Cost to the provider would be nominal if the reimbursement rates are reasonable. However, access to services by the patient would increase tremendously according to the law of moral hazard. Because this program is based on eligibility there would be an increase in utilization rates and an added cost upon initial treatment and evaluation to the patient. The cost to the patient would increase initially however because it is based on an income scale, it would be more affordable than an actual self-pay patient.

While this program provides access to healthcare coverage as well as continuity of care and healthcare education awareness, patients are only eligible if they are employed and have proof of employment and income. Therefore, expanding the program to all participating providers would not be a permanent solution to the financial and economical impact of the uninsured as expansion to participating providers would not necessarily equal enrollment of the working poor or eligibility.

The following matrices, Tables 6, 7, and 8 are visual representations of the effects of each proposal as weighed against each selected evaluative criteria.

Table 6.

Evaluation options for increasing access to care for the uninsured.

Policy Options	Access		
	Change in the uninsured population census	Change in the number of participating Primary Care providers	Change in number of uninsured with a provider home
Reform of Texas Indigent Care Programs and Requirements	(+) Great Increase	(+) Moderate Increase	(+/-) Minimal Increase
Restoration of Medicaid Medically Needy Spend-Down Program	(+)Moderate Increase due to program time limits. Restoration of the program does not equal access unless the provider piece is addressed.	(+) Moderate Increase	(+) Great Increase (at first)
Reformation of the State Medicaid and CHIP programs	(+) Moderate Increase due to program requirements.	(+) Great change to current primary care provider listing	Moderate Increase (+)
Expansion of the CareLink Program	Minimal Increase. This program is geared toward the working uninsured. (-)	(+) Great increase if the recipient can afford to pay based on CareLink guidelines.	Great Increase if recipient can afford to pay based on CareLink guidelines (+)
Status Quo	No change	(+) Moderate change as there are few participating providers	No change

Note. (+) indicates most favorable effect and (-) indicates most unfavorable effect.

Table 7.

Evaluation options for decreasing the costs of the uninsured in San Antonio.

	Cost (who gets the bill)		
Policy Options	Employers	Federal /State Government	Local County
Reform of Texas Indigent Care Programs and Requirements	(-) Minimal Increase	(+) Great Increase due to the funding mechanism	(-) Minimal Increase
Restoration of Medicaid Medically Needy Spend-Down Program	(-) No change	(+) Great Increase	(-) Minimal if any increase if any since the program is State/Federally funded
Reformation of the State Medicaid and CHIP programs	(-) No change	(+) Great Increase	No change
Expansion of the CareLink Program	Moderate change as program is geared toward the working uninsured paying for their care with employer based assistance.	No change	(-) Minimal Increase if recipient can afford to pay based on CareLink guidelines
Status Quo	No change	Great change	Minimal change

Note. (+) indicates increase effect on cost and (-) indicates no effect on cost.

Table 8.

Evaluation options for providing decreased barriers to patient centered care for the uninsured.

Policy Options	Decreased Barriers to care		
	Availability of Health Insurance coverage	Increase in reimbursement rates for providers	Education/preventative services
Reform of Texas Indigent Care Programs and Requirements	(+) Great Increase.	(+) Great Increase.	(+) Moderate Increase.
Restoration of Medicaid Medically Needy Spend-Down Program	(+) Great Increase. Access to low cost healthcare will allow patients to address acute illness before it becomes chronic.	(+) Great Increase	(+) Great Increase (at first)
Reformation of the State Medicaid and CHIP programs	(+) Moderate Increase due to program requirements.	(+) Great Increase	(+) Moderate Increase
Expansion of the CareLink Program	(-) Minimal Increase. This program is geared toward the working uninsured.	(+) Great increase if the recipient can afford to pay based on CareLink guidelines.	(+) No change
Status Quo	(+) Great change	(+) Great change	(+) Great change

Note. (+) indicates most favorable effect and (-) indicates most unfavorable effect.

Analysis of Trade-offs

The analysis of tradeoffs between any alternatives for providing healthcare which will both control the cost of healthcare coverage while ensuring the most cost effective healthcare methods essentially comes down to sacrifice. In other words, how much of X are we willing to sacrifice for Y. In this case, what are we willing to forgo in order to achieve access to healthcare coverage for the uninsured and indigent, with cost as the primary factor. The following analysis

will compare and contrast the aforementioned alternatives to status quo based on cost, access and barriers to patient centered care.

Reformation of the Texas Indigent Care Program is a great alternative to status quo which currently is to do nothing at all to assist the indigent in expanding eligibility and services. At best it allows for increased access to care by the indigent however it is limited to two establishments in San Antonio. This then allows for additional barriers to access including transportation, availability of services, and provider shortage just to name a few. The greatest opponent however is the cost to the county for proving the care without raising county taxes to ensure increased funding. Data from the University Hospital System in the Urgent Matters report of 2005 on indigent care and uncompensated care costs indicates that this will be a problem which will require continuous education and legislative support.

The Medically Needy Spend-down Program alternative is also another great alternative albeit a temporary one. Although temporary it would allow increase access to care, affordable coverage and less barriers to patient centered care for a period of time. However, there are two major detractors. First, patients are not required to commit to one specific primary care provider or facility for care thus continuity of care is an issue. Additionally the funding of this care across San Antonio would require that the counties fund the program across the state to ensure provider participation. Second, the cost to the county would be substantial to provide these temporary services without additional guaranteed funding from the state and federal government. Before the program was eliminated, it was cost effective to provide the care since Medicaid did pay the providers and hospitals partial payment for providing care with the state receiving over 60 percent in matching federal funds. Since the cuts the hospitals have lost not only the partial payment but also payments for uncompensated care which were tied directly to the program.

Now, providers and hospitals are reluctant to commit to a program which has no plan for making the program permanent or any guarantees for payment and funding support.

Reformation of the State Medicaid and CHIP is one alternative that if expanded to include enrollment waivers would prove to be the most effective alternative. Currently the program is the sole source of healthcare coverage for most children and allows for access to care to a primary provider home. Specific to children, it is the most efficient program to address the healthcare needs of over 20% of the total population. Additionally, it is the best alternative for continuity of care and individualized patient centered care. The cost however is an issue if funding continues to experience cuts from both the federal and state levels and if the state continues to ignore federal matching funds currently left on the table by Texas legislators to utilize for care. Additionally if funding is not restored the cost will be defrayed to local emergency rooms by those who are eligible but cannot access services due to the recent cuts and change in eligibility requirements resulting in a shift in costs from the government to local taxpayers.

Expansion of the CareLink Program is by far the least expensive of the alternatives to initiate and would have an enormous impact on the population; however, this is only specific to the working poor. Regardless of this limitation, CareLink does allow for increase access to care and affordable healthcare with a primary home. It also provides for continuity of care which extends to specialty care and emergency room visits. However, the requirements do not allow this program to extend beyond the boundaries of the working poor which makes it ineffective as a program to provide a solution to the uninsured and the indigent as a whole.

Recommendations

The goal of this policy analysis is to identify the best policy alternative(s) that will increase access to care for the uninsured in San Antonio Texas and at the same time improve the socio-economic standing of the community as a whole. A complex issue, there really is no one solution to the problem due to the density of the problem of the uninsured thus a combination of efforts to include combined policy changes and innovations at both the state and federal levels is necessary to address the problem of access to care . Ideally, implementation of all four alternatives would be best to resolve the access to health care dilemma and to address the growing cost of providing care to the uninsured in San Antonio, however, for purposes of this paper this is not a feasible solution.

To provide maximum access to care to the largest population of the uninsured while decreasing the cost of care to the hospital systems, the local community and improving the socio-economic status would require an alternative that focus on the young, our largest population of the uninsured, as well as those who can provide some economic stability. Addressing the healthcare needs of the young early, the future of the community, would allow for promotion of a health focused future. Ensuring that those working poor can afford their coverage and advance in life will empower the working poor to do better and will positively affect the economy. Therefore, expanding the CareLink Program as well as reforming the SCHIP would be most beneficial to produce the best outcomes. These two programs would address the grave disparities in healthcare coverage for the young while providing affordable healthcare to those who are working and contributing to the economy.

The two policy alternatives when combined will improve the health of the uninsured and provide access to care to all eligible families, while reducing the financial and economic burden

and rising healthcare costs. Additionally this combination of alternatives will allow for maximum patient education and prevention awareness which will also result in long term decrease in chronic care and diseases. It will also decrease ED visits and associated costs as the patients will have a primary and secondary healthcare home with continuity of care measures to address their healthcare needs. This would result in a healthier community with decrease absenteeism both in schools and in the work place and a more productive economic workforce.

By increasing access to healthcare coverage, and providing cost effective care through access to healthcare and insurance coverage combined with educational efforts and legislative support, Texas and San Antonio will decrease the financial burden in the form of uncompensated care costs of the uninsured and protect the health of its people while strengthening its economy.

Conclusion

Studies by the Institute of Medicine (IOM) have shown that when people are sick not only does it affect their productivity as an individual but their output in their production to the economy. Furthermore, the sick are more likely to use healthcare services if they can afford it and if it is available to them. While it is true that the rule of moral hazard often prevails, these same studies by the IOM showed that having insurance also facilitates more efficient use of resources. Since insured people are more likely to receive better healthcare awareness education, preventative care, medical home they are thus less likely to contribute to the over-utilization of the emergency departments. Regarding the economy, the Code Red Report indicated that the growing numbers of uninsured patients threaten economic stability, economic development, and the infrastructure for healthcare and prevention in the state (Code Red Report).

The purpose of this policy analysis is to identify the best policy alternative(s) to identify the best policy alternatives to increase access to healthcare coverage to the uninsured in San

Antonio community. To do so many facets that affect providing healthcare coverage and access to health insurance were addressesed. Research showed that the effects of lack of access directly affects the socioeconomic status of the community through low education rates, low paying jobs, increase absenteeism and an overall unhealthy population. To address these issues five alternatives were discussed to include status quo. Of the four alternatives, Reforming the Texas Indigent Care Program, Restoration of Medicaid Medically Needy Spend-Down Program, Reformation of the State Medicaid and CHIP program and Expansion of the CareLink Program, the best alternative which addresses both issues of access and its effect on the economy are to reform the State Medicaid and CHIP and to expand CareLink. These two programs address those who are lacking healthcare coverage as well as those who are currently contributing to the economy. Implementing these two programs by maximizing funding and legislative support, will allow affordable healthcare coverage, access to primary care homes, educational and preventative awareness, continuity of care, cost effective care and care that is efficient, effective, safe, timely and patient centered. This will result in decrease overhead cost to the healthcare organizations, decrease uncompensated care costs, a healthy population, a growing economy, higher education rates and better paying jobs. When combine the results of these two programs will not only increase access to health care coverage, decrease the financial burden on taxpayers and healthcare organizations but will also increase the economic benefits of the community through a healthier educated working population.

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Appendix A

Definition of terms:

Bad Debt: payment for which health care services are provided but payment was not received

Uncompensated care: Health care services provided by physicians and hospitals for which no payment is received from the patient or from third party payers.

Age: time in years pertaining to human life

Income: money received for work completed

Employment status: this indicates presence or absence in the labor force

Education level: Level of academic completion

Language: Communication tool experienced in sounds or symbols

Financial effects: monetary effects on the health system

Not for profit: organization/ society organized and operated solely for social / community welfare

For profit: A legal entity/ corporation that are organized for the benefit of its shareholders / owners

Private not for profit: Established for private profits and gains

Uninsured: Individuals without medical coverage

Underinsured: Individuals without adequate insurance coverage

Illegal immigrants: People who reside in the United States without proper documentation

Appendix B: Demographic Data General Characteristics: 2004 Bexar County, Texas

General Characteristics: 2004 Bexar County, Texas

Data Set: 2004 American Community Survey
Geographic Area: Bexar County, Texas
NOTE. Data are limited to the household population and exclude the population living in institutions, college dormitories, and other group quarters. For information on confidentiality protection, sampling error, nonsampling error, and definitions, see Survey Methodology.

Selected Economic Characteristics: 2004	Estimate	Lower Bound	Upper Bound
EMPLOYMENT STATUS			
Population 16 years and over	**1,085,254**	**1,081,118**	**1,089,390**
In labor force	704,843	692,534	717,152
Civilian labor force	693,099	680,383	705,815
Employed	631,441	617,316	645,566
Unemployed	61,658	53,411	69,905
Armed Forces	11,744	8,652	14,836
Not in labor force	380,411	367,426	393,396
Civilian labor force	**693,099**	**680,383**	**705,815**
Unemployed	8.9	7.7	10.1
Females 16 years and over	**569,151**	**565,936**	**572,366**
In labor force	324,793	316,655	332,931
Civilian labor force	320,239	312,128	328,350
Employed	293,817	284,951	302,683
Own children under 6 years	**139,212**	**133,255**	**145,169**
All parents in family in labor force	79,144	71,987	86,301
Own children 6 to 17 years	**245,382**	**238,308**	**252,456**
All parents in family in labor force	162,281	149,500	175,062
Population 16 to 19 years	**83,785**	**79,270**	**88,300**
Not enrolled in school and not a H.S. graduate	9,595	6,571	12,619
Unemployed or not in the labor force	5,966	3,367	8,565
COMMUTING TO WORK			
Workers 16 years and over	**615,881**	**601,439**	**630,323**
Car, truck, or van -- drove alone	494,829	479,859	509,799
Car, truck, or van – carpooled	65,152	53,574	76,730
Public transportation (excluding taxicab)	11,114	7,008	15,220
Walked	16,472	10,967	21,977
Other means	8,829	5,184	12,474

Appendix A. *General Characteristics: 2004 Bexar County, Texas continued*			
Worked at home	19,485	14,535	24,435
Mean travel time to work (minutes)	21.6	20.9	22.3
Employed civilian population 16 years and over	**631,441**	**617,316**	**645,566**
OCCUPATION			
Management, professional, and related occupations	202,952	188,682	217,222
Service occupations	113,474	102,839	124,109
Sales and office occupations	180,819	167,263	194,375
Farming, fishing, and forestry occupations	871	0	2,021
Construction, extraction, maintenance and repair occupations	70,502	60,846	80,158
Production, transportation, and material moving occupations	62,823	51,963	73,683
INDUSTRY			
Agriculture, forestry, fishing and hunting, and mining	1,963	570	3,356
Construction	50,419	41,741	59,097
Manufacturing	44,120	34,574	53,666
Wholesale trade	29,250	24,322	34,178
Retail trade	87,608	76,881	98,335
Transportation and warehousing, and utilities	26,549	22,232	30,866
Information	13,826	10,359	17,293
Finance and insurance, and real estate and rental and leasing	61,389	53,938	68,840
Professional, scientific, and management, and administrative and waste management services	61,166	53,084	69,248
Educational services, and health care, and social assistance	125,802	114,785	136,819
Arts, entertainment, and recreation, and accommodation, and food services	64,709	56,405	73,013
Other services, except public administration	32,964	26,694	39,234
Public administration	31,676	25,814	37,538
CLASS OF WORKER			
Private wage and salary workers	490,440	474,520	506,360
Government workers	98,465	88,541	108,389
Self-employed workers in own not incorporated business	42,123	35,504	48,742
Unpaid family workers	413	0	892

General Characteristics: 2004 Bexar County, Texas continued

INCOME AND BENEFITS (IN 2004 INFLATION-ADJUSTED DOLLARS)			
Total households	**512,627**	**505,825**	**519,429**
Less than $10,000	60,075	52,180	67,970
$10,000 to $14,999	28,678	23,742	33,614
$15,000 to $24,999	66,200	59,310	73,090
$25,000 to $34,999	73,171	63,424	82,918
$35,000 to $49,999	86,918	78,776	95,060
$50,000 to $74,999	88,438	80,197	96,679
$75,000 to $99,999	46,102	40,448	51,756
$100,000 to $149,999	41,817	36,160	47,474
$150,000 to $199,999	8,313	5,671	10,955
$200,000 or more	12,915	9,743	16,087
Median household income (dollars)	39,694	37,877	41,511
Mean household income (dollars)	54,536	51,832	57,240
With earnings	422,956	415,300	430,612
Mean earnings (dollars)	53,491	50,678	56,304
With Social Security	119,375	113,872	124,878
Mean Social Security income (dollars)	11,474	10,827	12,121
With retirement income	95,489	88,661	102,317
Mean retirement income (dollars)	21,404	19,871	22,937
With Supplemental Security Income	20,191	15,850	24,532
Mean Supplemental Security Income (dollars)	6,379	5,416	7,342
With cash public assistance income	13,728	10,346	17,110
Mean cash public assistance income (dollars)	2,084	1,435	2,733
With Food Stamp benefits in the past 12 months	54,968	46,532	63,404
Families	**361,621**	**349,790**	**373,452**
Less than $10,000	31,641	24,521	38,761
$10,000 to $14,999	14,772	10,605	18,939
$15,000 to $24,999	43,401	36,898	49,904
$25,000 to $34,999	44,106	36,724	51,488
$35,000 to $49,999	61,281	54,150	68,412
$50,000 to $74,999	69,740	62,620	76,860
$75,000 to $99,999	40,485	34,917	46,053
$100,000 to $149,999	37,220	31,699	42,741
$150,000 to $199,999	7,198	4,982	9,414
$200,000 or more	11,777	8,529	15,025
Median family income (dollars)	46,193	43,385	49,001
Mean family income (dollars)	62,473	58,801	66,145
Per capita income (dollars)	20,483	19,637	21,329

Nonfamily households	**151,006**	**140,879**	**161,133**
Median nonfamily income (dollars)	26,763	25,329	28,197
Mean nonfamily income (dollars)	33,865	31,532	36,198
Median earnings:	**22,101**	**21,305**	**22,897**
Male full-time, year-round workers (dollars)	36,175	33,942	38,408
Female full-time, year-round workers (dollars)	28,394	27,235	29,553
PERCENTAGE OF FAMILIES AND PEOPLE WHOSE INCOME IN THE PAST 12 MONTHS IS BELOW THE POVERTY LEVEL			
All families	14.6	12.1	17.1
With related children under 18 years	22	18.1	25.9
With related children under 5 years only	24.1	15.4	32.8
Married couple families	8.4	6.3	10.5
With related children under 18 years	13	9.6	16.4
With related children under 5 years only	19.1	9.9	28.3
Families with female householder, no husband present	36.8	29.7	43.9
With related children under 18 years	44.9	36.4	53.4
With related children under 5 years only	38.5	20.3	56.7
All people	17.2	14.8	19.6
Under 18 years	25.4	20.8	30
Related children under 18 years	25.3	20.7	29.9
Related children under 5 years	30.3	24	36.6
Related children 5 to 17 years	23.2	18.3	28.1
18 years and over	14	12.2	15.8
18 to 64 years	14.3	12.4	16.2
65 years and over	11.9	8.8	15
People in families	16.7	14	19.4
Unrelated individuals 15 years and over	22.5	19.5	25.5

Appendix B: Distribution of Total Population by Federal Poverty Level, States (2003-2004)IN Texas

	TX #	**TX %**	**US #**	**US %**
Under 100%	4,996,940	23	50,481,410	17
100-199%	4,633,180	21	54,647,220	19
Low Income Subtotal	9,630,110	44	105,128,620	36
200% +	12,420,090	56	185,157,720	64
Total	22,050,200	100	290,286,350	100

Appendix C: Medicaid and SCHIP enrollment in Bexar County

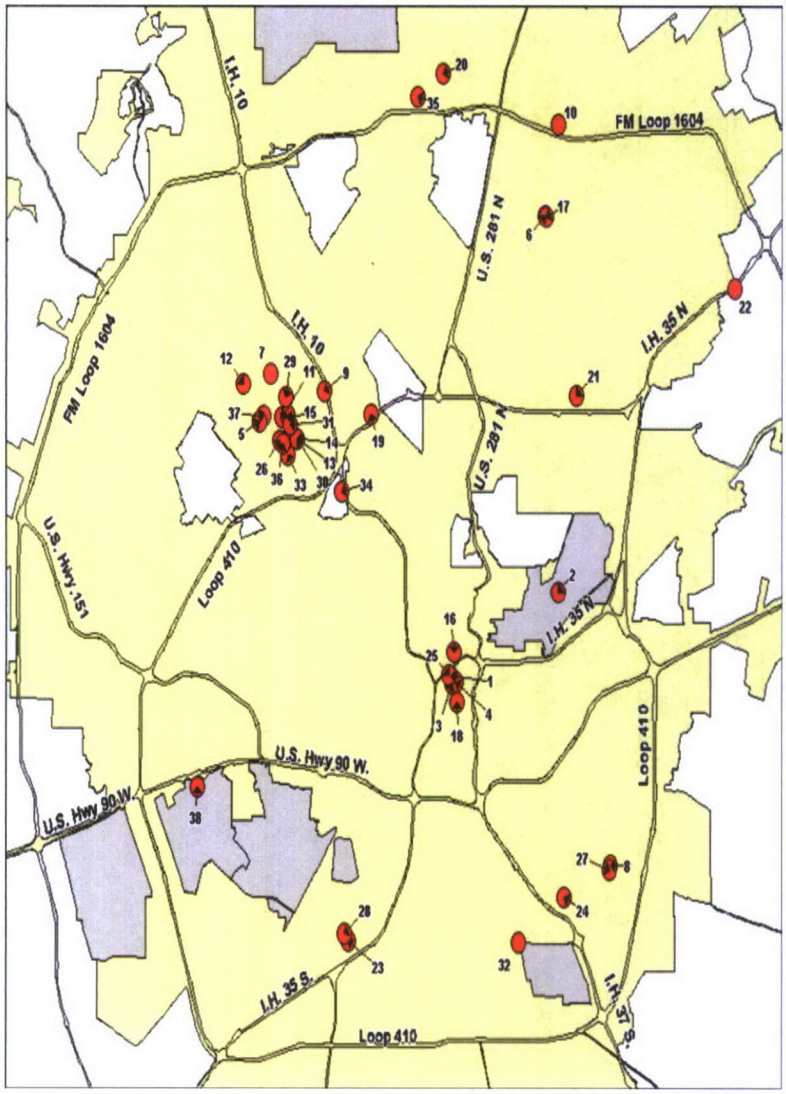
	Bexar County	**Texas**
Medicaid enrollment		
All ages	192,095	2,502,068
Ages 0-18	127,243	1,659,184
CHIP program		
Enrolled	28,545	464,191
Eligibility to be determined	32,420	486,407

Appendix D: CareLink Financial Obligation

UNIVERSITY HEALTH SYSTEM
CareLink Financial Obligation

ANNUAL INCOME	FAMILY SIZE 1	2	3	4	5	6	7	8
	2005 POVERTY GUIDELINES							
	$ 9,570.00	$ 12,830.00	$ 16,090.00	$ 19,350.00	$ 22,610.00	$ 25,870.00	$ 29,130.00	$ 32,390.00
$ 1,000.00	$ 0.24	$ 0.18	$ 0.14	$ 0.12	$ 0.10	$ 0.09	$ 0.08	$ 0.07
$ 2,000.00	$ 0.96	$ 0.71	$ 0.57	$ 0.47	$ 0.41	$ 0.35	$ 0.31	$ 0.28
$ 3,000.00	$ 2.16	$ 1.61	$ 1.28	$ 1.07	$ 0.91	$ 0.80	$ 0.71	$ 0.64
$ 4,000.00	$ 3.83	$ 2.86	$ 2.28	$ 1.89	$ 1.62	$ 1.42	$ 1.26	$ 1.13
$ 5,000.00	$ 5.99	$ 4.47	$ 3.56	$ 2.96	$ 2.53	$ 2.21	$ 1.97	$ 1.77
$ 6,000.00	$ 8.62	$ 6.43	$ 5.13	$ 4.26	$ 3.65	$ 3.19	$ 2.83	$ 2.55
$ 6,645.00	$ 10.57	$ 7.89	$ 6.29	$ 5.23	$ 4.48	$ 3.91	$ 3.47	$ 3.12
$ 7,178.00	$ 12.34	$ 9.20	$ 7.34	$ 6.10	$ 5.22	$ 4.56	$ 4.05	$ 3.65
$ 7,500.00	$ 13.47	$ 10.05	$ 8.01	$ 6.66	$ 5.70	$ 4.98	$ 4.43	$ 3.98
$ 8,000.00	$ 15.33	$ 11.43	$ 9.12	$ 7.58	$ 6.49	$ 5.67	$ 5.03	$ 4.53
$ 9,000.00	$ 19.40	$ 14.47	$ 11.54	$ 9.59	$ 8.21	$ 7.18	$ 6.37	$ 5.73
$ 9,623.00	$ 22.17	$ 16.54	$ 13.19	$ 10.97	$ 9.39	$ 8.20	$ 7.29	$ 6.55
$ 10,000.00	$ 23.95	$ 17.86	$ 14.24	$ 11.84	$ 10.14	$ 8.86	$ 7.87	$ 7.08
$ 10,500.00	$ 26.40	$ 19.69	$ 15.70	$ 13.06	$ 11.17	$ 9.77	$ 8.67	$ 7.80
$ 12,068.00	$ 34.87	$ 26.01	$ 20.74	$ 17.25	$ 14.76	$ 12.90	$ 11.46	$ 10.30
$ 13,575.00	$ 44.13	$ 32.92	$ 26.25	$ 21.82	$ 18.68	$ 16.32	$ 14.50	$ 13.04
$ 14,355.00	$ 49.35	$ 36.81	$ 29.35	$ 24.40	$ 20.89	$ 18.25	$ 16.21	$ 14.58
$ 14,513.00	$ 50.44	$ 37.62	$ 30.00	$ 24.95	$ 21.35	$ 18.66	$ 16.57	$ 14.90
$ 16,000.00	$ 61.30	$ 45.73	$ 36.46	$ 30.32	$ 25.95	$ 22.68	$ 20.14	$ 18.11
$ 16,391.00	$ 64.34	$ 47.99	$ 38.27	$ 31.82	$ 27.23	$ 23.80	$ 21.14	$ 19.01
$ 16,958.00	$ 68.86	$ 51.37	$ 40.96	$ 34.06	$ 29.15	$ 25.47	$ 22.62	$ 20.35
$ 17,720.00	$ 75.19	$ 56.09	$ 44.72	$ 37.19	$ 31.83	$ 27.82	$ 24.70	$ 22.22
$ 19,245.00	$ 88.69	$ 66.15	$ 52.75	$ 43.86	$ 37.54	$ 32.81	$ 29.14	$ 26.20
$ 19,403.00		$ 67.25	$ 53.62	$ 44.59	$ 38.16	$ 33.35	$ 29.62	$ 26.64
$ 21,000.00		$ 78.77	$ 62.81	$ 52.23	$ 44.70	$ 39.07	$ 34.69	$ 31.20
$ 21,500.00		$ 82.57	$ 65.84	$ 54.75	$ 46.85	$ 40.95	$ 36.37	$ 32.71
$ 21,848.00		$ 85.26	$ 67.99	$ 56.53	$ 48.38	$ 42.28	$ 37.55	$ 33.77
$ 23,000.00		$ 94.49	$ 75.34	$ 62.65	$ 53.62	$ 46.86	$ 41.62	$ 37.43
$ 24,293.00		$ 105.41	$ 84.05	$ 69.89	$ 59.82	$ 52.28	$ 46.43	$ 41.75
$ 24,500.00		$ 107.22	$ 85.49	$ 71.09	$ 60.84	$ 53.17	$ 47.22	$ 42.47
$ 25,000.00		$ 111.64	$ 89.02	$ 74.02	$ 63.35	$ 55.36	$ 49.17	$ 44.22
$ 25,660.00		$ 117.61	$ 93.78	$ 77.98	$ 66.74	$ 58.33	$ 51.80	$ 46.59
$ 29,025.00			$ 119.99	$ 99.77	$ 85.39	$ 74.63	$ 66.28	$ 59.61
$ 30,040.00			$ 128.53	$ 106.87	$ 91.46	$ 79.94	$ 70.99	$ 63.85
$ 32,180.00			$ 147.49	$ 122.64	$ 104.96	$ 91.73	$ 81.47	$ 73.27
$ 33,915.00				$ 136.22	$ 116.58	$ 101.89	$ 90.49	$ 81.38
$ 37,700.00				$ 168.33	$ 144.06	$ 125.90	$ 111.81	$ 100.56
$ 38,700.00				$ 177.38	$ 151.80	$ 132.67	$ 117.82	$ 105.96
$ 38,805.00					$ 152.63	$ 133.39	$ 118.46	$ 106.54
$ 43,695.00					$ 193.51	$ 169.13	$ 150.20	$ 135.08
$ 44,060.00					$ 196.76	$ 171.97	$ 152.72	$ 137.35
$ 45,220.00					$ 207.26	$ 181.14	$ 160.87	$ 144.68
$ 48,520.00						$ 208.54	$ 185.20	$ 166.56
$ 48,585.00						$ 209.10	$ 185.70	$ 167.01
$ 51,740.00						$ 237.14	$ 210.60	$ 189.41
$ 54,680.00							$ 235.22	$ 211.54
$ 56,780.00							$ 253.63	$ 228.10
$ 58,260.00							$ 267.03	$ 240.15
$ 64,780.00								$ 296.91

Appendix E: Bexar County Hospital Locations.



1 Baptist Medical Center
2 Brooke Army Medical Center
3 CHRISTUS Santa Rosa Children's Hospital
4 CHRISTUS Santa Rosa City Centre
5 Christus Santa Rosa Medical Center
6 Compass Hospital of San Antonio
7 HEALTHSOUTH RIOSA
8 Innova Hospital of San Antonio
9 Kindred Hospital San Antonio
10 Laurel Ridge Treatment Center
11 LifeCare Hospitals of San Antonio
12 Methodist Ambulatory Surgery Hospital
13 Methodist Children's Hospital
14 Methodist Hospital
15 Methodist Specialty & Transplant Hospital
16 Metropolitan Methodist Hospital
17 Mission Vista Behavioral Health System
18 Nix Health Care System
19 Nix Specialty Health Center
20 North Central Baptist Hospital
21 Northeast Baptist Hospital
22 Northeast Methodist Hospital
23 Promise Hospital
24 San Antonio State Hospital
25 Select Specialty Hospital-San Antonio, Inc.
26 South Texas Veterans Health Care System
27 Southeast Baptist Hospital
28 Southwest General Hospital
29 Southwest Mental Health Center
30 Southwest Texas Methodist Hospital
31 St. Luke's Baptist Hospital
32 Texas Center for Infectious Disease
33 Texas Specialty Hospital at San Antonio
34 TexSan Heart Hospital
35 The Spine Hospital of South Texas
36 University Health System
37 Warm Springs Rehabilitation Hospital
38 Wilford Hall Medical Center